

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

10604

**1. PLACE OF DEATH**

County Jackson Registration District No. 392 File No. \_\_\_\_\_  
 Township Leaw Primary Registration District No. 1003 Registered No. 1555  
 City Kansas City No. Kansas City Genl Hosp St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

McLain, Nellie  
 (a) Residence, No. 6020 Harrison St Ward 8  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 23 1918

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	11	0	11	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work School girl  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Indy Mo  
 (STATE OR COUNTRY)

10. NAME OF FATHER William McLain

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Laura Remond

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Iowa  
 (STATE OR COUNTRY)

14. INFORMANT Debra Clark  
 (Address) R.C. General Hosp

15. FILED 3/5 1929 M.M. Coward REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-4 1929

17. I HEREBY CERTIFY, That I attended deceased from 2-7 1929 to 3-4 1929  
 that I last saw him alive on 3-4 1929, 1929 and that death occurred, on the date stated above, at U.S. Gen. Hosp m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Epidemic Cerebro spinal meningitis

18. (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 CONTRIBUTORY (SECONDARY) 24

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Alin that I made  
 (Signed) P. Williams M. D.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Woodlawn Cemetery DATE OF BURIAL 3/6 1929

20. UNDERTAKER O. Mast ADDRESS 1915 East 15

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PARENTS

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